QUARTERLY RECERTIFICATION

Ryan White CARE Act Health Insurance Premium Payment

Client's name (Last)	(First)	(MI)	Social Security Number	Mother's Maiden Name

Policy Number	Monthly Premium	Premium due date	STATE USE ONLY: Total amount to be paid	STATE USE ONLY: Dates to be paid
	$		$ Quarterly	
Grace period				

MAKE PAYMENTS TO:

Payee's name	Telephone number		Contact person	
	( )			
Address (number, street)	City	State	ZIP code	Payee's Federal Tax ID number

DECLARATION: I am certified to enroll clients on the Ryan White CARE Act/Health Insurance Premium Payment (CARE/HIPP) program. I certify that a signature by _____ is on file authorizing _____ and the California Department of Public Health to obtain, if needed, any information regarding private health insurance coverage, including payments and/or medical care made on behalf of the client.

BENEFIT COUNSELOR AGENCY USE ONLY

Organization name	Benefits counselor name		Telephone number
			( )
Address (number, street)	City	ZIP code	FAX number
			( )

DECLARATION: All eligibility requirements for CARE/HIPP enrollment have been met.

Recert Number	Signature of Benefits Counselor	Date
4		
5		
6		
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STATE OF CALIFORNIA USE ONLY - AUTHORIZATION TO PAY PREMIUM

Welfare and Institutions Code, Section 14124.91, allows the California Department of Public Health to pay the premium for third-party coverage for eligible applicants.

The California Department of Public Health, Office of AIDS, authorizes the above payment(s) in the amount, for the period, and to the presentative payee as indicated.

Authorized signature	Date